DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/02/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185437	A. BUILDING _____ B. WING _____	01/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF LEBANON II	105 VILLAGE WAY LEBANON, KY 40033

RECEIVED
FEB 17 2011
Division of Health Care
Southern Enforcement Branch

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on January 17-19, 2011. Deficient practice was identified with the highest scope and severity at "D" level.	F 000	**STATEMENT:** **The preparation & execution of this POC does not constitute admission or Agreement by the provider of the truth of the facts alleged or conclusions set forth in the SOD. The POC is prepared & executed solely because it is required by federal and state law.**	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278	F278: *It is the policy and procedure of this facility that all assessments will accurately reflect the resident's status.* *A corrected MDS will be completed and submitted for resident # 2, 5, & 10.* *The last MDS submitted for all residents will be audited as their MDS's are due to identify any coding errors. Any errors identified will be corrected at that time.* *The MDS Coordinator will maintain a daily falls log to ensure that no falls are missed. The MDS Coordinator will also maintain a diagnosis log for each resident that will be updated as their MDS is due to ensure no diagnosis is missed.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Bland Ford MHA, LNHA | TITLE: Administrator | (X6) DATE: 2/11/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 by: Based on interview and record review it was determined the facility failed to accurately reflect the resident's status for three of twelve sampled residents (residents #2, #5, and #10). Residents #2 and #5 were not accurately assessed related to falls, and resident #10 was not accurately assessed related to diagnosis. The findings include: 1. Review of resident #2's medical record revealed the resident was admitted on September 1, 2005. Resident #2 had diagnoses of Congestive Heart Failure, Dementia, Hypertension, and Coronary Artery Disease. Further record review revealed resident #2 had sustained a fall on July 14, 2010, with no injury. Review of the Minimum Data Set (MDS) dated July 27, 2010, revealed no falls had occurred in the last 30 to 180 days. Interview with the MDS Coordinator on January 19, 2011, at 3:10 p.m., revealed resident #2's fall on July 14, 2010, should have been documented on the July 27, 2010 MDS assessment. Review of resident #10's medical record revealed the resident was admitted to the facility on October 11, 2007. Further review revealed resident #10 had diagnoses of Chronic Paranoid Schizophrenia, Dementia, Alzheimer's, Anxiety, Depression, Hypertension, and Chronic Urinary Tract Infection. Review of the MDS for resident #10 dated November 5, 2010, revealed no documentation of the diagnosis of Anxiety, Depression, or	F 278	*The MDS Coordinator will compare the daily falls log to the monthly incident log maintained by the DON as an audit to ensure compliance and this audit will be submitted to the Quality Assurance Committee to review for accuracy.* *The MDS Coordinator will also audit 5% of resident's diagnosis in charts quarterly to ensure compliance and will submit this report to this Quality Assurance Committee to review for accuracy.* *QA will follow this for one year* *2/11/11*	2/11/11

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F 278	Continued From page 2 Schizophrenia. Interview with the MDS Coordinator on January 19, 2011, at 3:10 p.m., revealed the diagnoses of Anxiety, Depression, and Schizophrenia should have been documented on resident #10's MDS assessment dated November 5, 2010. 2. Review of resident #5's medical record revealed diagnoses which included Dementia exacerbation, Depression, Coronary Artery Disease, Hypertension, and Protein Malnutrition. Review of resident #5's Annual Minimum Data Set (MDS) dated September 22, 2010, revealed no documentation that resident #5 had sustained a fall in the past 30-180 days. However, review of resident #5's medical record revealed the resident had fallen on June 17, 2010 and July 23, 2010. Therefore, the MDS was inaccurately coded. Observation of resident #5 revealed the resident's bed was in a low position, side rails were up on each side of the bed, a bed alarm was noted, and the facility had ensured the resident's call light was within reach during observations made from January 17-19, 2011. The above measures had been implemented per the resident's care plan to ensure safety and prevent further falls. Interview with the MDS Coordinator on January 18, 2011, at 2:25 p.m., revealed the Annual MDS should have been coded to reflect the falls documented for resident #5.	F 278		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	F323: It is the policy and procedure of this facility that the resident environment is free of accident hazards and that residents receive supervision and assistive devices to prevent accidents.	

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F 323	Continued From page 3 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the residents' environment remained as free of accident hazards as possible. On January 19, 2011, during the environmental tour observations, it was determined the facility failed to ensure three bottles of disinfectant cleaner, one bottle of multipurpose stain remover, and a package of razors were secure/locked and not accessible to residents. The findings include: Observation on January 19, 2011, at 12:00 p.m., in the resident shower room revealed a bottle of disinfectant cleaner containing quaternary ammonia compound hanging on the wall next to the sink, accessible to residents. Observation on January 19, 2011, at 12:10 p.m., in the whirlpool room revealed two bottles of disinfectant cleaner, one bottle of multipurpose stain remover, and a package of razors stored in a cabinet which was not locked, accessible to residents. Interview with the Housekeeping Director (HD) on January 19, 2011, at 12:10 p.m., revealed the cleaning agents and the disposable razors were required to be under lock and key and were not to be accessible to residents.	F 323	The bath aide had just finished giving baths for the day during this round and the disinfectant, multipurpose stain remover, and razors were immediately removed from the shower and whirlpool room upon their discovery. All residents use the shower and whirlpool room and are supervised by a bath aide the entire time that they are given a bath. All bath aides have received training from the CNA Coordinator that they are responsible for removing disinfectant, multipurpose stain remover, and razors from the shower/whirlpool room. The bath aide will store these items in the housekeeping closet which is locked and not accessible to residents. The CNA Coordinator will audit the shower/whirlpool rooms weekly to ensure the bath aide has properly stored all items. This audit will be submitted to the Quality Assurance Committee to ensure continued compliance. This will be followed by QA for one year.	1/24/11
F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR,	F 364		

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F 364 SS=D	Continued From page 4 PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to serve food at a palatable temperature. The findings include: Observation of the dinner meal at 5:36 p.m. on January 17, 2011, revealed a food cart was delivered to the North hall and then to the South hall. Observation revealed two resident trays left on the cart were taken back to the main dining room. Observation revealed the second food cart came out of the kitchen; staff removed the two remaining trays left on the first cart and placed the trays on the second cart. The second cart was taken to the Day room at 6:06 p.m. and the two trays from the first cart were pulled to serve resident #6 and resident #12. These trays were intercepted at that time in order to check the food temperatures, and to conduct a palatability test. The food trays had sat on the two carts for 30 minutes. The food temperatures revealed the chicken salad on resident #6's meal tray was 71.2 degrees Fahrenheit. Temperatures of food taken on resident #12's tray revealed the pureed chicken salad was 89.4 degrees Fahrenheit and the thickened milk was 55.3 degrees Fahrenheit.	F 364	It is the policy and procedure of this facility that every resident will receive food prepared by methods that conserve nutritive value, flavor, and appearance, and that the food is palatable, attractive, and at the proper temperature. Resident # 6 and #12 were ordered and served new meal trays. Dietary will audit the temperature of hall cart meals trays for residents that receive meals from the hall cart to ensure that meals are the proper temperature. Training was provided to all certified nursing assistants by the dietician on how to serve meals to residents including serving meals at the proper temperature, and serving meals from the hall cart. Dietary will continue to audit the temperature of meals served from the hall cart to ensure the proper temperature and will submit this to the Quality Assurance Committee. The QA Committee will review for one year to ensure a 95% threshold is met	2/14/11

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F 364	Continued From page 5 Interview with the Dietary Manager (DM) on January 17, 2011, revealed the chicken salad and thickened milk were not at acceptable temperatures for serving. The DM revealed this was not how the trays should have been served. The DM stated the facility had put in place a new system on January 17, 2011, due to the increased number of total fed residents and to ensure residents received food trays timely.	F 364		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	It is the policy and procedure of this facility that all drugs/biological used in the facility will be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. All drugs/biological identified were disposed of and reordered immediately. All opened drugs/ biological were also immediately audited and any found not to be dated were destroyed and reordered. The DON or designee will audit all opened drugs/biological at least weekly to ensure any opened drug/biological is dated. These audits will be submitted to the Quality Assurance Committee to ensure audits are being completed and medications are being labeled. QA will follow this for one year.	2/14/11

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F 431	Continued From page 6 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to label and date all drugs and biologicals in accordance with currently accepted professional principles. Two bottles of Novolin R, two bottles of Lantus, one bottle of Humulin N, one bottle of Levemir, three bottles of eye drops, and one bottle of Bacteriostatic 0.9% Sodium Chloride had been opened and were available for use; however, the medications were not dated to indicate the date the bottles were opened. The findings include: Observations on January 19, 2011, at 1:48 p.m., of the facility's medication rooms/carts revealed a bottle of Bacteriostatic 0.9% Sodium Chloride had been opened and remained available for use. Further observation revealed the vial failed to indicate the date the vial was opened. Observation revealed two bottles of Novolin R, two bottles of Lantus, one bottle of Humulin N, and one bottle of Levemir had been opened but were not dated to indicate when the bottles were opened. Observation further revealed three bottles of eye drops were opened with no date to indicate when the bottles were opened. Interview with the DON on January 19, 2011, at	F 431		

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F 431	Continued From page 7 1:48 p.m., revealed staff was required to date all insulin and eye drops when opened. Further interview revealed the facility did not have a policy regarding the requirement of dated medications.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	F441 It is the policy and practice of this facility that an Infection Control Program exists to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection. A new system for meal delivery was created where staff were trained by the dietician to carry trays from the hall cart directly into the resident's room. Also, the dietary department immediately began to cover every item on every tray coming out of the kitchen. The dietary department has also ordered new bowls that have lids and will use these bowls and lids on meal trays. The dietary department will do a monthly audit of meal trays and will submit this audit to the quality assurance committee.	1/24/11

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F 441	Continued From page 8 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain proper infection control practices related to staff members serving food to residents during the dinner meal observation. The findings include: Observation on January 17, 2011, at 5:30 p.m., revealed staff passing meal trays to residents on the North and South halls. The meal cart contained trays for each hall. Observation revealed staff carrying five meal trays into resident rooms that were over 20 to 40 feet from the meal cart and the jello on the meal tray was uncovered. Observation also revealed one staff person carrying a meal tray from the kitchen, down the North hall, to the South hall with the jello on the meal tray noted to be uncovered. An interview conducted on January 19, 2011, at 11:00 a.m., with the Administrator revealed the facility had initiated a new system for meal delivery on January 17, 2011. The Administrator stated staff was to carry trays from the cart directly into the resident's room instead of carrying trays up and down the hallways.	F 441		

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on January 20, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that an exit had a durable surface to the public way. This deficient practice affected one of three smoke compartments, staff, and approximately ten residents. The facility has the capacity for 64 beds with a census of 54 on the day of the survey. The findings include: During the Life Safety Code tour on January 20, 2011, at 10:50 a.m., an interview with the Director of Maintenance (DOM) revealed the exterior exit that was cited on March 2, 2010, due to not having a durable surface outside the exit had not been corrected. The deficient exit was located next to resident room 19. This exit was observed to lead to a grassy area. Exits must have a durable surface to the public way to support	K 038	K038 This facility called the fire marshal after our March 2nd survey to discuss options for installing a durable surface to the public way and our OIG POC as any change to our emergency exits also have to be approved by the Fire Marshall. The fire marshal stated that he wanted to look at the exit before giving any direction and came for a site visit in May. At that time the Fire Marshal took our building plans (blueprints) to Frankfort and the Fire Marshal stated he would get back to us regarding making changes to the east hall fire exit. The Fire Marshal returned to the facility with our blueprints on November 1st, 2010 and gave us the okay to proceed with our POC. The concrete company that had been contracted to pour our durable surface was contacted at that time. They stated that the weather was inclement and we would not be able to pour this durable surface until the spring when the weather cleared up. At this time we are waiting for warmer weather and will proceed with our plans for installing our durable surface as stated in our 2010 POC.	2/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Blandford MHA LNHA	Administrator	2/11/11

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K 038	Continued From page 1 wheelchairs, beds, equipment, etc., in case of an emergency situation. The facility alleged in a plan of correction dated March 22, 2010, that the exterior exit would be corrected as soon as weather permitted. However, according to the DOM, the exit exterior had not been corrected.	K 038		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the sprinkler system according to NFPA standards. This deficient practice affected three of three smoke compartments, staff, and all the residents. The facility has the capacity for 64 beds with a census of 54 on the day of the survey. The findings include: Observation during the Life Safety Code tour on January 20, 2011, at 11:00 a.m., with the Director of Maintenance (DOM) of the facility's sprinkler system riser revealed a valve in the off position to the accelerator. An accelerator ensures the proper operation of the sprinkler system. An interview with the DOM on January 20, 2011, at 11:00 a.m., revealed the valve was turned off because the accelerator needed to be repaired/replaced. A quarterly inspection by the sprinkler contractor	K 062	K062 B&B Fire Protection Inc was at this facility on 12/30/10 to conduct a quarterly sprinkler inspection and stated that the accelerator needed to be rebuilt or replaced. This was stated that B&B would return at a later time to complete this work. B&B was contacted on 1/20/11 and reminded that the accelerator needed to be rebuilt/replaced. B&B arrived on 1/21/11 and completed this work.	1/21/11

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185437	A. BUILDING 02 - MAIN BUILDING 01 B. WING _____	01/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF LEBANON II	105 VILLAGE WAY LEBANON, KY 40033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 2 dated December 30, 2010, revealed the contractor did not document that the accelerator was not working correctly. According to the DOM, the sprinkler contractor was aware the accelerator needed repair during this inspection; however, there was not a work order or plan for someone to fix the accelerator. Reference: NFPA'25 (1998 Edition). 1-6.1 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date.	K 062		